

FEDERAL DOT CMV MEDICAL EXAMINATION REQUIREMENTS

Please read carefully BEFORE your visit as you are responsible for this information. Please contact Valley Medical Center's Occupational Medicine Department with questions PRIOR to your appointment.

We strongly encourage all drivers to present for their exam 60 days before their previous certification expires with appropriate documentation to prevent a lapse in certification. Should the Department of Transportation uncover evidence that a driver was untruthful, said driver will lose their license.

As of May 21, 2014, massive regulatory changes went into effect governing DOT examinations as well as those providing examinations. The list provided below is a summation of the most common conditions that had modifications; however, this is NOT an exhaustive list. That is, you may have a condition not listed here that may prevent or delay your certification. You may access the exhaustive list at: <https://www.fmcsa.dot.gov/regulations/medical/driver-medical-requirements/medical-examiners-handbook-2024-edition>

Please note that a specialist (IE: cardiologist, neurologist, etc.) who states that you are cleared to drive DOES NOT guarantee certification. There are very specific waiting periods and testing that must be followed in addition to this clearance.

VISION: If you require correction to your vision, you must wear your corrective lenses during your exam. If you have been told that your vision is worse than 20/40 in both eyes with correction or if you are legally blind in one eye, you will not pass. There is an exemption for monocular vision, however you MUST have that documentation available at the time of the exam.

HEARING: Should you require hearing aids, you must bring them to your appointment and undergo a hearing assessment on the day of your exam. If you do not pass, you will need to see an audiologist and will not be certified on the day of the exam.

CARDIAC HISTORY: If you have ANY cardiac history, you will need a letter from your cardiologist/treating provider that you are medically optimized. Below are some of the conditions requiring such documentation, however this list is NOT all inclusive:

- **MYOCARDIAL INFARCTION (Heart Attack):** **Mandatory** waiting period of two months after MI (even if cleared by cardiology). You must have a letter from a cardiologist/treating provider indicating you are medically optimized. You MUST have a stress test, and echocardiogram results available at your DOT exam.

- **CORONARY ARTERY STENTS:** Mandatory waiting period of one week minimum and longer if associated with a MI. Stress test results are required EVERY SIX MONTHS, and you will need to have a completed document with results and statement from the provider at the time of your DOT exam.
- **CORONARY ARTERY BYPASS GRAFT (CABG):** Mandatory waiting period of THREE MONTHS regardless of cardiology clearance. You MUST have an echocardiogram and yearly stress test with results available at your DOT exam.
- **HEART DISEASE:** Must have a letter of medically optimized state by cardiologist/treating provider.
- **ARRHYTHMIA:** Mandatory waiting period of one month after being diagnosed. Will need echocardiogram, cardiologist clearance, and a stress test with documentation available at your DOT exam.
- **ANGINA (Chest Pain):** Requires stress test and documentation from provider available at your DOT exam.
- **PACEMAKER:** You must bring documentation on your most recent annual pacemaker check, and this MUST BE dated within the last twelve months. You will also need a letter from your cardiologist/treating provider stating the specific indication for your pacemaker. Having a DIFIBRILLATOR will disqualify a driver immediately.
- **HYPERTENSION (High Blood Pressure):** Maximum certification is one year. Blood pressure MUST BE 140/90 or less DURING your DOT exam or your certification may be delayed, or you may be disqualified.
- **ANEURYSM (Dilated Blood Vessels):** For abdominal, thoracic, other, or surgery for an aneurysm, you will need a letter from your VASCULAR surgeon clearing you to drive a commercial vehicle. Maximum certification is one year. If an aneurysm is present and measures over 5 cm, you will not pass per federal regulations.

NEUROLOGY: If you have had a stroke or mini stroke, severe head injury, intracranial bleeding, brain infection, dizziness or passing out spells (syncope), a neurology consult will be required BEFORE your DOT exam. Documentation from the specialist is required at your DOT exam.

DIABETES: There are very tight regulations on diabetes management. If you take insulin, you will not be certified to drive if you do not have an exemption from the NRCME. To begin the exemption process, call 708-448-3094. This does take UP TO SIX MONTHS, so please plan accordingly. Regulations suggest that Hemoglobin A1C be less than 10% and blood sugars are within 100-400. If these requirements are not met, certification may be delayed so that you may see your provider for treatment regulation.

LUNG DISEASE: If you are a smoker over the age of 35, have asthma, COPD, or other respiratory illness, you will need to have spirometry completed during your visit. There are specific regulations regarding these results that may delay certification.

MENTAL HEALTH: if you are being treated for adult depression, any psychiatric diagnosis, or Attention-Deficit/Hyperactivity (ADHD), you need to provide documentation regarding your diagnosis, treatment plan, including medication from your treating provider for clearance to drive a commercial vehicle.

SUBSTANCE ABUSE: You must have documentation from a SAP (Substance Abuse Professional) who works directly within the DOT standards. You will NOT be certified without this documentation. You may find these providers by online search in your area.

BLOOD THINNERS: Warfarin (Coumadin) requires documentation of monthly INR results and the reason you are on Coumadin. You must have a therapeutic INR within one month of your certification. Documentation must be provided at your DOT exam.

LOSS OF LIMB/FUNCTION: There is an exemption available for drivers who have lost a limb or part of a limb but can still drive. This must be present at your exam for certification. This can be obtained through the FMCSA.

SLEEP APNEA: All patients will undergo a sleep apnea screening during the DOT exam.

WHAT TO BRING TO YOUR DOT EXAMINATION APPOINTMENT:

- ☐ COMPLETE medication list to include any over-the-counter medications you take.
- ☐ Full list of your medical and surgical history.
- ☐ All required documentation as outlined above.

We truly want to make the DOT Physical Exam process as efficient as possible. As DOT Medical Examiners, we MUST follow the regulations as dictated and are not allowed to alter the regulations regardless of the consequences to a driver's certification. **IF, AFTER READING THIS INFORMATION, YOU NEED TO RESCHEDULE YOUR APPOINTMENT, PLEASE LET OUR STAFF KNOW.** Thank you for your understanding and we apologize for any inconvenience.

In Good Health,

DOT Medical Examiners
Valley Medical Center

SIGN HERE

I have read this document and understand its contents. I also understand that once my appointment has begun, my DOT Physical Examination fee is not refundable.

Patient Signature

Date

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Medical Programs Division, Federal Motor Carrier Safety Administration, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

(or sticker)

SECTION 1. Driver Information (to be filled out by the driver)**PERSONAL INFORMATION**

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____ Age: _____

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____

E-Mail (optional): _____ CLP/CDL Applicant/Holder*: Yes No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? Yes No Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below.

Yes No Not Sure

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)?
If "yes," please describe below.

Yes No Not Sure

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Not			Not		
	Yes	No	Sure	Yes	No	Sure
1. Head/brain injuries or illnesses (e.g., concussion)						
2. Seizures/epilepsy						
3. Eye problems (except glasses or contacts)						
4. Ear and/or hearing problems						
5. Heart disease, heart attack, bypass, or other heart problems						
6. Pacemaker, stents, implantable devices, or other heart procedures						
7. High blood pressure						
8. High cholesterol						
9. Chronic (long-term) cough, shortness of breath, or other breathing problems						
10. Lung disease (e.g., asthma)						
11. Kidney problems, kidney stones, or pain/problems with urination						
12. Stomach, liver, or digestive problems						
13. Diabetes or blood sugar problems Insulin used						
14. Anxiety, depression, nervousness, other mental health problems						
15. Fainting or passing out						
16. Dizziness, headaches, numbness, tingling, or memory loss						
17. Unexplained weight loss						
18. Stroke, mini-stroke (TIA), paralysis, or weakness						
19. Missing or limited use of arm, hand, finger, leg, foot, toe						
20. Neck or back problems						
21. Bone, muscle, joint, or nerve problems						
22. Blood clots or bleeding problems						
23. Cancer						
24. Chronic (long-term) infection or other chronic diseases						
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring						
26. Have you ever had a sleep test (e.g., sleep apnea)?						
27. Have you ever spent a night in the hospital?						
28. Have you ever had a broken bone?						
29. Have you ever used or do you now use tobacco?						
30. Do you currently drink alcohol?						
31. Have you used an illegal substance within the past two years?						
32. Have you ever failed a drug test or been dependent on an illegal substance?						

Other health condition(s) not described above: Yes No Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: Yes No Not Sure

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of [49 CFR 390.35](#), and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under [49 CFR 390.37](#) and [49 CFR 386](#) Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)***DRIVER HEALTH HISTORY REVIEW**

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

TESTING

Pulse Rate: _____ Pulse rhythm regular: Yes No Height: ____ feet ____ inches Weight: ____ pounds

Blood Pressure

Systolic

Diastolic

Sitting

 Second reading
(optional)
Urinalysis

Sp. Gr.

Protein

Blood

Sugar

 Urinalysis is required.
Numerical readings
must be recorded.

Other testing if indicated

 Protein, blood, or sugar in the urine may be an indication for further testing to
rule out any underlying medical problem.
Vision
 Standard is at least 20/40 acuity (Snellen) in each eye with or without correction.
At least 70° field of vision in horizontal meridian measured in each eye. The use of
corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/ ____	20/ ____	Right Eye: ____ degrees
Left Eye:	20/ ____	20/ ____	Left Eye: ____ degrees
Both Eyes:	20/ ____	20/ ____	Yes No

 Applicant can recognize and distinguish among traffic control
signals and devices showing red, green, and amber colors

Monocular vision

Referred to ophthalmologist or optometrist?

Received documentation from ophthalmologist or optometrist?

Hearing
 Standard: Must first perceive whispered voice at not less than 5 feet **OR** average
hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test:	Right Ear	Left Ear	Neither
Whisper Test Results			
Record distance (in feet) from driver at which a forced whispered voice can first be heard	Right Ear	Left Ear	
	_____	_____	

OR**Audiometric Test Results**

Right Ear:				Left Ear:			
500 Hz	1000 Hz	2000 Hz		500 Hz	1000 Hz	2000 Hz	
_____	_____	_____		_____	_____	_____	
Average (right): _____				Average (left): _____			

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System

Normal Abnormal

1. General
2. Skin
3. Eyes
4. Ears
5. Mouth/throat
6. Cardiovascular
7. Lungs/chest

Body System

Normal Abnormal

8. Abdomen
9. Genito-urinary system including hernias
10. Back/spine
11. Extremities/joints
12. Neurological system including reflexes
13. Gait
14. Vascular system

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV.
Enter applicable item number before each comment.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

Does not meet standards (specify reason): _____

Meets standards in [49 CFR 391.41](#); qualifies for 2-year certificate

Meets standards, but periodic monitoring required (specify reason): _____

Driver qualified for: 3 months 6 months 1 year other (specify): _____

Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (specify type): _____

Accompanied by a Skill Performance Evaluation (SPE) Certificate

Driving within an exempt intracity zone (see [49 CFR 391.62](#)) (Federal)

Determination pending (specify reason): _____

Return to medical exam office for follow-up on (must be 45 days or less): _____

Medical Examination Report amended (specify reason): _____

(if amended) Medical Examiner's Signature: _____ Date: _____

Incomplete examination (specify reason): _____

If the driver meets the standards outlined in [49 CFR 391.41](#), then complete a Medical Examiner's Certificate as stated in [49 CFR 391.43\(h\)](#), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name (please print or type): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date:

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations ([49 CFR 391.41-391.49](#)) with any applicable State variances (which will only be valid for intrastate operations):

Does not meet standards in [49 CFR 391.41](#) with any applicable State variances (specify reason): _____Meets standards in [49 CFR 391.41](#) with any applicable State variances

Meets standards, but periodic monitoring required (specify reason): _____

Driver qualified for: 3 months 6 months 1 year other (specify): _____

Wearing corrective lenses Wearing hearing aid Accompanied by a waiver/exemption (specify type): _____

Accompanied by a Skill Performance Evaluation (SPE) Certificate Grandfathered from State requirements (State)

If the driver meets the standards outlined in [49 CFR 391.41](#), with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name (please print or type): _____

Medical Examiner's Address: _____ City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____ Date Certificate Signed: _____

Medical Examiner's State License, Certificate, or Registration Number: _____ Issuing State: _____

MD DO Physician Assistant Chiropractor Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: _____

Medical Examiner's Certificate Expiration Date:

Instructions for Completing the Medical Examination Report Form (MCSA-5875)

I. Step-By-Step Instructions

Driver:

Section 1: Driver Information

- **Personal Information:** Please complete this section using your name as written on your driver's license, your current address and phone number, your date of birth, age, driver's license number and issuing state.
 - **CLP/CDL Applicant/Holder:** Check "yes" if you are a commercial learner's permit (**CLP**) or commercial driver's license (**CDL**) holder, or are applying for a CLP or CDL. CDL means a license issued by a State or the District of Columbia which authorizes the individual to operate a class of a commercial motor vehicle (**CMV**). A CMV that requires a CDL is one that: (1) has a gross combination weight rating or gross combination weight of 26,001 pounds or more inclusive of a towed unit with a gross vehicle weight rating (**GVWR**) or gross vehicle weight (**GVW**) of more than 10,000 pounds; or (2) has a GVWR or GVW of 26,001 pounds or more; or (3) is designed to transport 16 or more passengers, including the driver; or (4) is used to transport either hazardous materials requiring hazardous materials placards on the vehicle or any quantity of a select agent or toxin.
 - **Driver ID Verified By:** The Medical Examiner/staff completes this item and notes the type of photo ID used to verify the driver's identity such as, commercial driver's license, driver's license, or passport, etc.
 - **Has your USDOT/FMCSA medical certificate ever been denied or issued for less than two years?** Please check the correct box "yes" or "no" and if you aren't sure check the "not sure" box.
- **Driver Health History:**
 - **Have you ever had surgery:** Please check "yes" if you have ever had surgery and provide a written explanation of the details (type of surgery, date of surgery, etc.)
 - **Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements):** Please check "yes" if you are taking any diet supplements, herbal remedies, or prescription or over the counter medications. In the box below the question, indicate the name of the medication and the dosage.
 - **#1-32:** Please complete this section by checking the "yes" box to indicate that you have, or have ever had, the health condition listed or the "No" box if you have not. Check the "not sure" box if you are unsure.
 - **Other Health Conditions not described above:** If you have, or have had, any other health conditions not listed in the section above, check "Yes" and in the box provided and list those condition(s).
 - **Any yes answers to questions #1-32 above:** If you have answered "yes" to any of the questions in the Driver Health History section above, please explain your answers further in the box below the question. For example, if you answered "yes" to question #5 regarding heart disease, heart attack, bypass, or other heart problem, indicate which type of heart condition. If you checked "yes" to question #23 regarding cancer, indicate the type of cancer. Please add any information that will be helpful to the Medical Examiner.
- **CMV Driver Signature and Date:** Please read the certification statement, sign and date it, indicating that the information you provided in Section 1 is accurate and complete.

Medical Examiner:

Section 2: Examination Report

- **Driver Health History Review:** Review answers provided by the driver in the driver health history section and discuss any “yes” and “not sure” responses. In addition, be sure to compare the medication list to the health history responses ensuring that the medication list matches the medical conditions noted. Explore with the driver any answers that seem unclear. Record any information that the driver omitted. As the Medical Examiner conducting the driver’s physical examination you are required to complete the entire medical examination even if you detect a medical condition that you consider disqualifying, such as deafness. Medical Examiners are expected to determine the driver’s physical qualification for operating a commercial vehicle safely. Thus, if you find a disqualifying condition for which a driver may receive a Federal Motor Carrier Safety Administration medical exemption, please record that on the driver’s Medical Examiner’s Certificate, Form MCSA-5876, as well as on the Medical Examination Report Form, MCSA-5875.
- **Testing:**
 - **Pulse rate and rhythm, height, and weight:** record these as indicated on the form.
 - **Blood Pressure:** record the blood pressure (systolic and diastolic) of the driver being examined. A second reading is optional and should be recorded if found to be necessary.
 - **Urinalysis:** record the numerical readings for the specific gravity, protein, blood and sugar.
 - **Vision:** The current vision standard is provided on the form. When other than the Snellen chart is used, give test results in Snellen-comparable values. When recording distance vision, use 20 feet as normal. Record the vision acuity results and indicate if the driver can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors; has monocular vision; has been referred to an ophthalmologist or optometrist; and if documentation has been received from an ophthalmologist or optometrist.
 - **Hearing:** The current hearing standard is provided on the form. Hearing can be tested using either a whisper test or audiometric test. Record the test results in the corresponding section for the test used.
- **Physical Examination:** Check the body systems for abnormalities and indicate normal or abnormal for each body system listed. Discuss any abnormal answers in detail in the space provided and indicate whether it would affect the driver’s ability to safely operate a commercial motor vehicle.

In this next section, you will be completing either the Federal or State determination, not both.

- **Medical Examiner Determination (Federal):** Use this section for examinations performed in accordance with the FMCSRs ([49 CFR 391.41-391.49](#)). Complete the medical examiner determination section completely. When determining a driver’s physical qualification, please note that English language proficiency ([49 CFR part 391.11](#): General qualifications of drivers) is not factored into that determination.
 - **Does not meet standards:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in [49 CFR 391.41](#).
 - **Meets standards in [49 CFR 391.41](#); qualifies for 2-year certification:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner’s Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified for, and if selecting “other” specify the time frame.
 - **Determination that driver meets standards:** Select all categories that apply to the driver’s certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, driving within an exempt intracity zone, etc.).
- **Determination pending:** Select this option when more information is needed to make a qualification decision and specify a date, on or before the 45 day expiration date, for the driver to return to the medical exam office for follow-up. This will allow for a delay of the qualification decision for as many as 45 days. If the disposition of the pending examination is not updated via the National Registry on or before the 45 day expiration date, FMCSA will notify the examining medical examiner and the driver in writing that the examination is no longer valid and that the driver is required to be re-examined.
 - **MER amended:** A Medical Examination Report Form (MER), MCSA-5875, may only be amended while in determination pending status for situations where new information (e.g., test results, etc.) has been received or there has been a change in the driver’s medical status since the initial examination, but prior to a final qualification determination. Select this option when a Medical Examination Report Form, MCSA-5875, is being amended; provide the reason for the amendment, sign and date. In addition, initial and date any changes made on the Medical Examination Report Form, MCSA-5875. A Medical Examination Report Form, MCSA-5875, cannot be amended after an examination has been in determination pending status for more than 45 days or after a final qualification determination has been made. The driver is required to obtain a new physical examination and a new Medical Examination Report Form, MCSA-5875, should be completed.
- **Incomplete examination:** Select this when the physical examination is not completed for any reason (e.g., driver decides they do not want to continue with the examination and leaves) other than situations outlined under determination pending.
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.
- **Medical Examiner’s Certificate Expiration Date:** Enter the date the **driver’s** Medical Examiner’s Certificate (MEC) expires.
- **Medical Examiner Determination (State):** Use this section for examinations performed in accordance with the FMCSRs ([49 CFR 391.41-391.49](#)) with any applicable State variances (which will only be valid for intrastate operations). Complete the medical examiner determination section completely.
 - **Does not meet standards in [49 CFR 391.41](#) with any applicable State variances:** Select this option when a driver is determined to be not qualified and provide an explanation of why the driver does not meet the standards in [49 CFR 391.41](#) with any applicable State variances.
 - **Meets standards in [49 CFR 391.41](#) with any applicable State variances:** Select this option when a driver is determined to be qualified and will be issued a 2-year Medical Examiner’s Certificate.

- **Meets standards, but periodic monitoring is required:** Select this option when a driver is determined to be qualified but needs periodic monitoring and provide an explanation of why periodic monitoring is required. Select the corresponding time frame that the driver is qualified for, and if selecting “other” specify the time frame.
 - **Determination that driver meets standards:** Select all categories that apply to the driver’s certification (e.g., wearing corrective lenses, accompanied by a waiver/exemption, etc.).
- **Medical Examiner information, signature and date:** Provide your name, address, phone number, occupation, license, certificate, or registration number and issuing state, national registry number, signature and date.
- **Medical Examiner’s Certificate Expiration Date:** Enter the date the **driver’s** Medical Examiner’s Certificate (MEC) expires.

- II. **If updating an existing exam, you must resubmit the new exam results, via the Medical Examination Results Form, MCSA-5850, to the National Registry, and the most recent dated exam will take precedence.**
- III. **To obtain additional information regarding this form go to the Medical Program’s page on the Federal Motor Carrier Safety Administration’s website at <http://www.fmcsa.dot.gov/regulations/medical>.**

STOP-BANG Screening Questionnaire

Is it possible that you have ... Obstructive Sleep Apnea (OSA)?

Please answer the following questions below to determine if you might be at risk.

SNORING? Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

- ☐ Yes
- ☐ No

TIRED? Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

- ☐ Yes
- ☐ No

OBSERVED? Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

- ☐ Yes
- ☐ No

PRESSURE? Do you have or are being treated for **High Blood Pressure**?

- ☐ Yes
- ☐ No

BODY MASS INDEX MORE THAN 35 KG/M²?

- ☐ Yes
- ☐ No

AGE OLDER THAN 50?

- ☐ Yes
- ☐ No

NECK SIZE LARGE? (Measured around Adams apple). Does your shirt collar measure 16 inches or larger?

- ☐ Yes
- ☐ No

GENDER = MALE?

For General Population:

OSA - Low Risk : Yes to 0 - 2 questions

OSA - Intermediate Risk : Yes to 3 - 4 questions

OSA - High Risk : Yes to 5 - 8 questions

or Yes to 2 or more of 4 STOP questions + male gender

or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m²

or Yes to 2 or more of 4 STOP questions + neck circumference 16 inches